



Health Plan Benefits Group

DATE: July 29, 2004

LETTER TO: All Managed Care Organizations (MCOs)

SUBJECT: Transition From the Legacy Group Health Plan (GHP) System to the Medicare Managed Care System (MMCS) – **ACTION**

As stated in the 2005 Call Letter we were to provide you with more details regarding the implementation of the MMCS. This letter provides more detail about the cutover from the GHP system to the MMCS. It includes information regarding

- New transaction reply codes,
- Transaction reply report data changes,
- Working aged (WA) data submittal process (including an update on WA ESRD status),
- Employer group health plan (EGHP) membership reporting, (effective 1/2005)
- ESRD transplant reporting,
- Monthly membership report (MMR) changes related to EGHP reporting and the ESRD payment model, (effective 1/2005)
- Rejected/failed transaction processing and
- Railroad Retirement Board (RRB) claim number processing.

General

Our current projection is that the MMCS will assume the processing of managed care enrollments and beneficiary-level payments from the GHP system immediately after the September 1, 2004 monthly run in mid-August. MMCS training sessions have been conducted periodically over the last 2 years and additional sessions will be presented at this year's Managed Care Enrollment and Payment Conference in September. An MMCS Tutorial is available at <https://cms.hhs.gov/healthplans/systems> that can provide hands-on experience.

New Transaction Reply Codes

Several new codes will be utilized by MMCS. They were provided to you in the 2005 Call Letter. They are described below including any actions that the MCO is required to take.

Code 150 – OVER CAP LIMIT – An enrollment has been accepted, but the capacity limit has been exceeded. If the MCO has instituted an enrollment limit beyond which

medical services cannot be delivered in a satisfactory manner, the beneficiary should be disenrolled. Please note, however, that this reply is informational in nature and subsequent action is at the option of the MCO.

Code 151 – DISROL BAD RC – A disenrollment is accepted, but the disenrollment reason code was invalid. This is a future use code; you will be notified when it will be activated along with the list of valid reason codes and how they can be corrected.

Code 152 – NEW RACE CODE – The race code of a beneficiary has changed. No action need be taken. The purpose of the race code is to provide information for quality initiatives that an MCO may be conducting.

Code 153 – TEMP ADR EXPIRE – The temporary address of a beneficiary has changed, but s/he still resides in the service area. This code is informational for the MCO.

Code 154 – OUT OF AREA – The beneficiary's address had changed and s/he is no longer in the service area of the plan benefit package (PBP) that s/he is currently enrolled in. The MCO can either (1) move the member to another PBP that is offered where s/he resides or (2) disenroll the member from the MCO.

Code 155 – INCARCERATED – The beneficiary has become incarcerated. Action in this situation depends on the MCO's coverage requirements. If services can be provided to incarcerated members, then they may remain in the MCO. If not, they must be disenrolled.

Code 156 – BAD USR FOR PLN – A batch file was rejected as it was submitted by a user not authorized by that MCO. MMCS will only accept batch transactions from users authorized by that MCO. Contact your CMS technical representative for further direction.

Code 157 – UNAUT REQUEST – A transaction is rejected because it was submitted by an MCO that is not authorized to submit that transaction type. An example is that only certain types of organizations can submit nursing home certifiable transactions. If the MCO believes that they are authorized to submit a specific transaction type, contact your CMS technical representative for further direction.

Code 158 – INST CHANGE – CMS or contractor staff revised or cancelled an institutional period for a member. If the MCO believes that the modification was erroneous, follow the standard procedures related to submitting retroactive adjustment requests in Section F of Chapter 19 in the Medicare Managed Care Manual.

Code 159 – NHC CHANGE – CMS or contractor staff revised or cancelled a nursing home certifiable period for a member. If the MCO believes that the modification was erroneous, follow the standard procedures related to submitting retroactive adjustment requests in Section F of Chapter 19 in the Medicare Managed Care Manual.

Code 160 – UNAUT BATCH SUB – A batch file was rejected as it was submitted by a user not authorized by that MCO. MMCS will only accept batch transactions from users authorized by that MCO to submit batch files. Contact your CMS technical representative for further direction.

In addition to the new codes, MMCS may create multiple reply codes in some situations to provide more information to the MCO. An example is for a state and county code (SCC) change that results in a member being outside of the service area, MMCS will generate a code 85 (SCC change) as GHP does today and also a code 154 (out of area).

Transaction Reply Report Data Changes

There are 2 minor changes to the display of data on the reply reports.

- (1) AAPCC Payment Rate Fields (on report and data file formats) – MMCS will display the total Part A and Part B payment amounts applicable to the member. Previously this field was populated with the AAPCC rates for the state and county associated with the member.
- (2) Entitlement Type Code (on data file format only) – MMCS will populate a Y if the member has Part A **and** Part B; otherwise the field will be blank. Previously this field was populated by numerous type codes from another CMS system.

Working Aged (WA) Data Submittal Process

The working aged data submittal process as implemented under the legacy GHP system continues unchanged for 2004. This data will be used in computing payments during calendar year 2005. However, because of the implementation of the new risk adjustment for ESRD, MCO's will be required to survey all ESRD enrollees, regardless of age.

- Survey members as reflected by the March 2004 monthly membership report. If a member has since disenrolled, attempt to obtain a current survey from him/her. If there is no response, you may use the results of the prior survey.

NOTE: You may use the results of surveys conducted between January – September of 2004.

- **UPDATE.** Per the 45-day notice of 2005 Payment Methodology Changes (Enclosure 3, Section C), due to the higher payment levels associated with these members, the ESRD model is calibrated assuming proper application of Medicare Secondary Payer (MSP) status. This calibration was applied to the entire ESRD population; therefore, you must survey all of your ESRD members. This includes individuals under the age of 65. The MSP adjustment will be included in the individual risk adjustment scores on appropriate beneficiaries. These would be the members that you report (or we find on CWF for nonrespondents) as WA. These members will remain at their assigned status (WA or non WA) for the

entire payment year. We would expect that more ESRD members would be assigned a WA status, than for non ESRD members. In addition, because of the importance of determining MSP status for ESRD enrollees, we will be identifying additional methods for improving the accuracy of MSP data.

- For members that are defined as working aged, report member-level information to CMS in an EXCEL spreadsheet. It is to be submitted on a separate diskette than the Nonrespondent data (see below). If you are reporting for multiple contracts, working aged data for each contract is to be in a separate EXCEL file on the diskette. **Do not submit data on sheets within EXCEL files, you must put each contract in a separate file.** The columns for the EXCEL spreadsheet are to be as follows.

TITLE	Name the EXCEL file “Working Aged.2005Pmt.HXXXX”, X = your contract number
1	Contract Number
2	Medicare HIC#
3	Last Name
4	First Name
5	Date of Birth in YYYYMMDD Format

- For members that are NOT defined as working aged, report nothing.
- For nonrespondents, report member-level information to CMS in an EXCEL spreadsheet. It is to be submitted on a separate diskette than the WA data (see above). If you are reporting for multiple contracts, nonrespondent data for each contract is to be in a separate EXCEL file on the diskette. **Do not submit data on sheets within EXCEL files, you must put each contract in a separate file.** The columns for the EXCEL spreadsheet are to be as follows.

TITLE	Name the EXCEL file “Nonrespondents.2005Pmt.HXXXX”, X = your contract number
1	Contract Number
2	Medicare HIC#
3	Last Name
4	First Name
5	Date of Birth in YYYYMMDD Format

- **M+COs must submit this data on diskettes by September 15, 2004 to**

CMS
C/O Angela Wright
C1-05-17
7500 Security Blvd.
Baltimore, MD 21244

- Please confirm that you have sent this data by e-mail listing a contact person (with an e-mail address and telephone number) to

KMIEGEL@CMS.HHS.GOV
AWRIGHT@CMS.HHS.GOV

Upon review of the diskettes, CMS will confirm receipt of your data.

Employer Group Health Plan (EGHP) Enrollment Reporting

As stated in the 2005 Call Letter, CMS will begin to track enrollment of EGHP members. A field has been added to the enrollment transaction, EGHP Flag (position 42), for this purpose. (See Attachment A.) Beginning in January 2005, MCOs are to report the EGHP status for new members on the enrollment transactions by putting a Y. If the member is not an EGHP member, leave the field blank.

CMS will auto-populate the EGHP flag for all members of the EGHP-only PBPs. A method for reporting of this status for the remaining members of MCOs will be defined by mid-2005. A field will be added to the MMR (position 194) so that you will know which members you will have to report this status for at that time. (See Attachment C.)

ESRD Transplant Reporting

As stated in the 45-day notice of 2005 Payment Methodology Changes, the ESRD information system will be the source for identifying members who receive kidney transplants. It also stated that MCOs have the option of notifying CMS directly of a transplant, as in some cases, this may result in a more timely payment.

We have discussed this issue with staff from the ESRD networks and the ESRD information system, and have been assured that the system is being updated with the transplant information within 5 days. We believe that because this timeframe is as good or better than could be realized via manual reporting, the latter method will not be needed. Of course we are going to validate and monitor system updates to ensure that the 5-day timeframe is adhered to. If we find that the rate of the system updates would compromise the ability of CMS to make a timely payment, an alternate method will be identified and you will be notified.

ESRD Payment Model – Monthly Membership Report (MMR) Changes

CMS has expanded the Graft and Post-Graft factor types as follows.

- The Graft (transplant) factor will be expanded to two factors. The first factor will be the larger of the two factors, and will apply to the month of the transplant. The second factor will be the smaller of the two factors and will apply to the two months immediately following the month of the transplant.

- The functioning graft (post-graft) factor originally was going to be two factors per beneficiary, community and institutional. The final model will produce two community functioning graft factors and two institutional functioning graft factors for each beneficiary. The factors will be a 4-9 month factor and a 10+ month factor. The first factor, the 4-9 month factor, will be applied immediately following the third transplant factor month (i.e., the fourth month), as long as the beneficiary does not return to dialysis status or have another transplant. The second factor will start at the tenth month and continue until the beneficiary either returns to dialysis status or has another transplant.
- New enrollee functioning graft (post-graft) factors will similarly double, meaning that new enrollees will now have a 4-9 month functioning graft factor and a 10+ month functioning graft factor.

The revised coding scheme for the risk adjustment factor type field on the MMR will be as follows.

CODE	NAME	DESCRIPTION	APPLIES TO
C	Community	Beneficiary is not institutionalized or, per MDS, is institutionalized, but for less than 90 days.	Experienced
C1	Community/Post-Graft - 1	Beneficiary is not institutionalized or, per MDS, is institutionalized, but for less than 90 days. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 4-9 following the transplant.	Experienced
C2	Community/Post-Graft - 2	Beneficiary is not institutionalized or, per MDS, is institutionalized, but for less than 90 days. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 10+ following the transplant.	Experienced
D	Dialysis	Beneficiary is undergoing dialysis treatments.	Experienced
I	Institutional	Per MDS, the beneficiary is institutionalized for 90 or more days. This factor is NOT impacted by institutional transactions submitted by MCOs, this is strictly long-term care as reported in the MDS.	Experienced

I1	Institutional/Post-Graft - 1	Per MDS, the beneficiary is institutionalized for 90 or more days. This factor is NOT impacted by institutional transactions submitted by MCOs, this is strictly long-term care as reported in the MDS. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 4-9 following the transplant.	Experienced
I2	Institutional/Post-Graft - 2	Per MDS, the beneficiary is institutionalized for 90 or more days. This factor is NOT impacted by institutional transactions submitted by MCOs, this is strictly long-term care as reported in the MDS. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 10+ following the transplant.	Experienced
E	New Enrollee	Beneficiary has less than 12 months of Medicare coverage.	New
ED	New Enrollee/Dialysis	Beneficiary has less than 12 months of Medicare coverage. Beneficiary is undergoing dialysis treatments.	New
E1	New Enrollee/Post-Graft - 1	Beneficiary has less than 12 months of Medicare coverage. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 4-9 following the transplant.	New
E2	New Enrollee/Post-Graft - 2	Beneficiary has less than 12 months of Medicare coverage. The beneficiary also has had a successful kidney transplant and is no longer dialyzing. This factor is used for months 10+ following the transplant.	New
G1	Graft - 1	Beneficiary has received a kidney transplant. This factor will be used to compute payment for the month of the transplant. After this month, the Graft 2 factor is used.	Both

G2	Graft - 2	Beneficiary has received a kidney transplant. This factor will be used to compute payment for the 2 months following the month of the transplant. After this 2-month period, the factor reverts to the Dialysis factor (graft unsuccessful) or the Post-Graft 1 factor (graft successful).	Both
-----------	------------------	---	------

Rejected/Failed Transaction Processing

MMCS differentiates between fatal errors (transactions that cannot be edited) and rejects (transactions that fail membership or payment edits). Fatal errors are written to a “failed transaction file”; rejects are written to a “rejected transaction file”.

- Rejected Transactions

As part of its new functionality, MMCS will allow MCOs to review, repair and re-submit rejected transactions. Three methods are supplied; MCOs may use any or all of them:

- Download the Transaction Reply/Monthly Activity data file, process the exceptions, and re-submit transactions in the next monthly run. In MMCS, this process will be identical to GHP—same dataset names, file and record formats. The Transaction Reply/Monthly Activity data file will be made available once a month, after payment approval; for this reason, this option does not allow the MCO to resubmit a transaction in the same month.
- Use the MMCS user interface (UI) screens to locate the rejected transactions, correct them and resubmit them. Because it allows the correction of one record at a time, this option may be most effective for small numbers of rejected records. An MCO can use the UI option many times during the month—and may choose to correct only some of the rejects at a time. Procedures for using the MMCS UI to locate, correct and resubmit rejected records are included in the MMCS version of the Plan Communications Users Guide, and a summary is also provided in the MMCS MCO Tutorial.
- Download the rejected transaction file, process the rejects according to existing MCO procedures, and re-submit the corrected records in the same month. This batch option may be most appropriate for large numbers of rejected records. This functionality had no parallel in GHP; therefore, it requires new processing on the part of those MCOs who choose to use this option.

The naming convention of the rejected transaction file will be [xxxxx.@bgd5050.transfer.data.rejects](#), where ‘xxxxx’ is the UserID associated with the individual at the MCO who is responsible for exchanging files with CMS. The file will have the following format.

Element	Positions	Type	Length	Description
1	1-80	Character	80	Original transaction (correction, enrollment, disenrollment, PBP change), exactly as received from the MCO.
2	81-83	Character	3	Transaction Reply Code – 1 NOTE: 5 iterations of reply code are allowed, as one transaction may generate more than one reply code.
3	84-86	Character	3	Transaction Reply Code – 2
4	87-88	Character	3	Transaction Reply Code – 3
5	89-91	Character	3	Transaction Reply Code – 4
6	92-94	Character	3	Transaction Reply Code – 5

- Failed Transactions

As part of its new functionality, MMCS will allow MCOs to review and download failed transactions. Because “failed” transactions cannot be read by MMCS, MCOs have fewer options for resubmitting them.

- Download the Transaction Reply/Monthly Activity data file, process the exceptions, and re-submit transactions in the next monthly run. In MMCS, this process will be identical to GHP, and is the same as the process for rejected transactions.
- Because MMCS cannot “read” failed transactions, the MMCS user interface (UI) screens *cannot* be used to locate, correct or resubmit failed transactions.
- Download the failed transaction file, process the failed records according to existing MCO procedures, and re-submit the corrected records in the same month.

The naming convention of the failed transaction file will be [xxxx.@bgd5050.transfer.data.failed](#), where 'xxxx' is the UserID associated with the individual at the MCO who is responsible for exchanging files with CMS. The file will have the following format.

Element	Positions	Type	Length	Description
1	1-8	Character	8	User ID of individual submitting the original transaction.
2	9-34	Character	26	Time stamp.
3	35-37	Character	3	Transaction Reply Code
4	38-41	Character	4	Request Group ID number
5	42-121	Character	80	Original transaction (correction, enrollment, disenrollment, PBP change), exactly as received from the MCO.

RRB Claim Number Processing

RRB health insurance claim numbers have an internal (11byte) and an external format (12 byte). For the initial implementation of MMCS, the external format must be used on all batch transactions. In addition, only the external format will be contained on your monthly reports. You will be notified when MMCS has been changed to accept and report both formats.

Example

External Format: WCH345678900

Internal Format: C4567890083

Additional information regarding MMCS access and system testing will be provided to you in a separate letter.

If you have any questions regarding the information contained in this letter, please contact your Central Office representative listed in Attachment B.

/s/

Marla K. Kilbourne
Director, Division of Enrollment
and Payment Operations

3 Attachments

ATTACHMENT A – ENROLLMENT TRANSACTION – EGHP FIELD

Effective 1/2005

<u>Field</u>	<u>Size</u>	<u>Position</u>	<u>Remarks</u>
Claim Number	12	1 - 12	Nine-byte SSN of primary beneficiary (Beneficiary Claim Account Number); two-byte BIC (Beneficiary Identification Code); one-byte filler (except RRB)
Surname	12	13 - 24	Beneficiary Surname
First Name	7	25 - 31	Beneficiary Given Name
Middle Initial	1	32	Beneficiary Middle Initial
Sex	1	33	Beneficiary Sex Identification Code 1 = Male 2 = Female 0 = Unknown
Date of Birth	8	34 - 41	Beneficiary Birth Date; YYYYMMDD format
EGHP Flag	1	42	Y = EGHP member; otherwise blank
PBP Identifier	3	43 – 45	Identification number of Plan Benefit Package
Filler	1	46	Spaces
Contract Number	5	47 - 51	Contract Number
Application Signature Date	8	52 - 59 signed	Date the applications was signed YYYYMMDD format
Transaction Code	2	60 - 61	Beneficiary GHP Transaction Type Code 51 = Disenroll 60 = Employer Group Enroll* 61 = Enroll 71 = PBP Election
Disenrollment Reason	2	62 - 63	Disenrollment reason code
Effective Date	8	64 - 71	Transaction Effective Date; YYYYMMDD format
[Filler]	8	72 - 79	Spaces
Prior Commercial	1	80	Beneficiary GHP Prior Commercial Month Count 0 - 9, A - F = number of months a beneficiary was enrolled in Plan on a commercial basis prior to Plan's Medicare contract; otherwise, blank

ATTACHMENT B – CENTRAL OFFICE CONTACT LIST

Boston:	Jacqueline Buise (410)786-7607 Jbuisse@cms.hhs.gov
New York:	Juan Lopez (410)786-7621 Jlopez@cms.hhs.gov
Philadelphia:	James Dorsey (410)786-1143 Jdorsey1@cms.hhs.gov
Atlanta:	Gloria Webster (410)786-7655 Gwebster@cms.hhs.gov
Chicago:	Janice Bailey (410)786-7603 Jbailey1@cms.hhs.gov
Dallas:	Joanne Weller (410)786-5111 Jweller@cms.hhs.gov
Kansas City:	Gloria Webster (410)786-7655 Gwebster@cms.hhs.gov
Denver:	Luigi Distefano (410)786-7611 LDistefano@cms.hhs.gov
San Francisco:	Ed Howard (410)786-6368 Ehoward1@cms.hhs.gov
Seattle:	David Evans (410)786-0412 Devans2@cms.hhs.gov

ATTACHMENT C – MMR LAYOUT
Effective 1/2005

#	Field Name	Len	Pos	Description
1	MCO Contract Number	5	1-5	MCO Contract Number
2	Run Date of the File	8	6-13	YYYYMMDD
3	Payment Date	6	14-19	YYYYMM
4	HIC Number	12	20-31	Member's HIC #
5	Surname	7	32-38	
6	First Initial	1	39-39	
7	Sex	1	40-40	M = Male, F = Female
8	Date of Birth	8	41-48	YYYYMMDD
9	Age Group	4	49-52	BBEE BB = Beginning Age EE = Ending Age
10	State & County Code	5	53-57	
11	Out of Area Indicator	1	58-58	Y = Out of Contract-level service area Always Spaces on Adjustment
12	Part A Entitlement	1	59-59	Y = Entitled to Part A
13	Part B Entitlement	1	60-60	Y = Entitled to Part B
	Demographic Health Status Indicators:			
14	Hospice	1	61-61	Y = Hospice
15	ESRD	1	62-62	Y = ESRD
16	Working Aged	1	63-63	Y = Working Aged
17	Institutional	1	64-64	Y = Institutional

#	Field Name	Len	Pos	Description
18	NHC	1	65-65	Y = Nursing Home Certifiable
19	Medicaid	1	66-66	Y = Medicaid Status
	Risk Adjuster Indicators:			
20	FILLER	1	67-67	SPACES
21	Medicaid Indicator	1	68-68	Y = Medicaid Addon
*22	PIP-DCG	2	69-70	PIP-DCG Category - <i>Only on pre-2004 adjustments</i>
*23	Default Indicator	1	71-71	Y = default RA factor in use <ul style="list-style-type: none"> For pre-2004 adjustments, a “Y” indicates that a new enrollee RA factor is in use For post-2003 payments and adjustments, a “Y” indicates that a default factor was generated by the system due to lack of a RA factor.
24	Risk Adjuster Factor A	7	72-78	NN.DDDD
25	Risk Adjuster Factor B	7	79-85	NN.DDDD
	Fields 26 - 30 applicable to both Demographic and Risk Adjuster:			
26	Number of Paymt/Adjustmt Months Part A	2	86-87	99
27	Number of Paymt/Adjustmt Months Part B	2	88-89	99
28	Adjustment Reason Code	2	90-91	99 Always Spaces on Payment
29	Paymt/Adjustmt Start Date	8	92-99	YYYYMMDD
30	Paymt/Adjustmt End Date	8	100-107	YYYYMMDD

#	Field Name	Len	Pos	Description
31	Demographic Paymt/Adjustmt Rate A	9	108-116	-\$\$\$\$\$.99
32	Demographic Paymt/Adjustmt Rate B	9	117-125	-\$\$\$\$\$.99
33	Risk Adjuster Paymt/Adjustmt Rate A	9	126-134	-\$\$\$\$\$.99
34	Risk Adjuster Paymt/Adjustmt Rate B	9	135-143	-\$\$\$\$\$.99
35	Blended Paymt/Adjustmt Rate A	9	144-152	-\$\$\$\$\$.99
36	Blended Paymt/Adjustmt Rate B	9	153-161	-\$\$\$\$\$.99
37	Total Paymt/Adjustmt	9	162-170	-\$\$\$\$\$.99
	Additional Risk Adjuster Indicators:			
*38	FILLER	1	171-171	SPACES
39	Risk Adjuster Age Group (RAAG)	4	172-175	BBEE BB = Beginning Age EE = Ending Age
40	Previous Disable Ratio (PRDIB)	7	176-182	NN.DDDD Percentage of Year (in months) for Previous Disable Add-On – <i>Only on pre-2004 adjustments</i>
41	FILLER	1	183-183	SPACES
42	FILLER	1	184-184	SPACES
43	Plan Benefit Package Id	3	185-187	Plan Benefit Package Id FORMAT 999

#	Field Name	Len	Pos	Description
44	Race Code	1	188-188	Format X Values: 0 = Unknown 1 = White 2 = Black 3 = Other 4 = Asian 5 = Hispanic 6 = N. American Native
*45	RA Factor Type Code	2	189-190	Type of factors in use (see Fields 24-25): C = Community C1 = Community Post-Graft1 C2 = CommunityPost-Graft2 D = Dialysis E = New Enrollee ED = New Enrollee Dialysis E1 = New Enrollee Post-Graft1 E2 = New Enrollee Post-Graft 1 G1 = Graft1 G2 = Graft2 I = Institutional I1 = Institutional Post-Graft 1 I2 = Institutional Post-Graft 2
*46	Frailty Indicator	1	191-191	Y = MCO-level Frailty Factor Included
*47	Previously Disabled Indicator	1	192-192	Y = Previously Disabled – Only on post-2003 payments/adjustments
*48	Lag Indicator	1	193-193	Y = Encounter data used to calculate RA factor lags payment year by 6 months
*49	EGHP Flag	1	194-194	Y = EGHP member; otherwise blank
*50	FILLER	6	195-200	SPACES